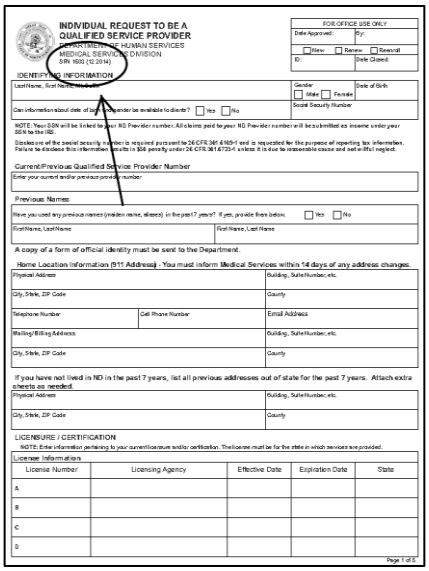
# FAMILY HOME CARE QSP ENROLLMENT
## FORM PACKET

**This packet contains all necessary forms for you to enroll as a QSP.**
**The following forms are <u>required</u> for you to enroll:**


- ✓ SFN 1604 –Request to be a Qualified Service Provider For Family Home Care
  **(ALWAYS include a <u>copy</u> of a form of ID, ex: driver's license or social security card)**
- ✓ SFN 1168 – Ownership/Controlling Interest and Conviction Information
- ✓ SFN 433 – Child Abuse & Neglect Background Inquiry
- ✓ SFN 615 – Medicaid Program Provider Agreement
- ✓ W9 – Request for Taxpayer Identification Number & Certification

It is important that you always send the most updated version of these forms to HCBS. If we receive outdated forms, they will be returned to you**,** <u>which will delay your enrollment</u>. Please check our website (http://www.nd.gov/eforms/) to make sure you have the most recent version of forms or call our office at 701-328-4602 with any questions on how to complete the forms. The form number and the date each form was revised can be found at the top left of the form (shown below).



INDIVIDUAL REQUEST TO BE A QUALIFIED SERVICE PROVIDER

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1603 (12-2014)

FOR OFFICE USE ONLY
Date Approved: By:
New Renew Reenroll
ID: Date Closed:

IDENTIFYING INFORMATION

Last Name, First Name, MI
Gender: Male Female
Date of Birth
Can information about date of birth be released to clients? Yes No
Social Security Number

NOTE: Your SSN will be linked to your ND Provider number. All claims paid to your ND Provider number will be submitted as income under your SSN to the IRS.

Disclosure of the social security number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in $50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not willful neglect.

Current/Previous Qualified Service Provider Number

Enter your current and/or previous provider number

Previous Names

Have you used any previous names (maiden name, aliases) in the past 7 years? If yes, provide them below: Yes No

First Name, Last Name
First Name, Last Name

A copy of a form of official identity must be sent to the Department.

Home Location Information (911 Address) - You must inform Medical Services within 14 days of any address changes.

Physical Address
Building, Suite Number, etc.
City, State, ZIP Code
County
Telephone Number
Cell Phone Number
Email Address
Mailing/Billing Address
Building, Suite Number, etc.
City, State, ZIP Code
County

If you have not lived in ND in the past 7 years, list all previous addresses out of state for the past 7 years. Attach extra sheets as needed.

Physical Address
Building, Suite Number, etc.
City, State, ZIP Code
County

LICENSURE / CERTIFICATION

NOTE: Enter information pertaining to your current license and/or certification. The license must be for the state in which services are provided.

License Information

| | License Number | Licensing Agency | Effective Date | Expiration Date | State |
|---|---|---|---|---|---|
| A | | | | | |
| B | | | | | |
| C | | | | | |
| D | | | | | |

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**If you have any questions, please call the HCBS Office 1-800-755-2604 or 701-328-4602.**

# INSTRUCTIONS TO COMPLETE ENROLLMENT FORMS

The forms must be **completed with a pen or typed** and submitted to:
Medical Services/HCBS Division
600 E Boulevard Ave Dept. 325
Bismarck ND 58505-0250

**Instructions to Complete**
**SFN 1604 Request to be a Qualified Service Provider For Family Home Care**

**IDENTIFYING INFORMATION:**
Fill in Name, Gender, and Date of Birth
Answer question if your date of birth and gender can be shared with clients.
**Write in Social Security Number**

**Current/Previous ND Provider Number:**
If you are currently enrolled as a QSP, or have been enrolled as a QSP in the past, write in your Provider #.

**Previous Names:**
Answer the question. If yes, list all previous names used in the past 7 years.

**NOTE: A COPY OF A FORM OF AN OFFICIAL IDENTITY DOCUMENT MUST BE SENT TO THE DEPARTMENT; example**: driver's license, tribal ID card etc.
Failure to send an ID will slow the process

**Home location information:** Write in your complete physical or 911 address including county. A PO Box cannot be accepted.

**Mailing/Billing Address information:**
Write in your address where you receive mail and where you want your checks sent.

**If you have not lived in North Dakota in the past 7 years, what were your previous addresses?** If this applies write in all information. If there is more than one address please write on an additional sheet and send to the Department.

**Provider Specialty Information:**
Write in the client's name and relationship to you.

**Languages Supported:**
Check any and all languages that you can speak, read, write, and understand.

**Check county service is provided in.**

**ELECTRONIC FUNDS TRANSFER:**
Check yes if you want your payments direct deposited into your bank account. Then complete all information.
**Attach a voided check or documentation from your financial institution which has the financial routing number.**
Must include:

- Your name and Address
- Banking institution Name and Adress
- Bank Routing Number and Account Number

**REMITTANCE ADVICE:**
If you bill via the web portal, you will receive a PDF version of your RA via the web portal.
If you bill paper, you will receive a paper RA.

**CLAIMS SUBMISSION**
Check if you will use online billing via North Dakota Health Enterprise Portal by internet or paper billing by mailing or delivering your billing form.

**QUESTIONS:**
**#1** Check the last grade of school completed.

**#2a Do** you have the basic ability to read, write, and verbally communicate in English?

**#2b Do** you need someone to help you read, write, and verbally communicate in English?

**If unable to read and write, and verbally communicate in English, contact the HCBS Department for additional forms. (701-328-4602)**

**# 3** Have you ever been convicted of a felonly, or misdemeanor offense or are you presently on probation?

**If yes, attach required reports.**

**#4 to #10 Read each statement carefully and then honestly mark yes or no.**

**Supply all needed records to eliminate a delay in processing your application.**

If checked yes, provide name of Adult Foster Home and provide forms SFN 466 and SFN 467 if new applicant or reenroll.

**Initial each of the following to indicate your understanding and agreement:**

- Listed are assurances that you must make to enroll as a QSP. Read each statement carefully and then initial. All must be initialed for the form to be complete.
- If you have questions about the assurances contact the HCBS Provider Enrollment Administrator at 701-328-4579.

**SIGNATURE:**

Your signature verifies that the information being sent is true and correct to the best of your knowledge, and that you are aware this is a public document. Note that providing false information may be the reason for the Department to deny or cancel any qualified service provider agreements.

**Print your name, sign, and then date.**

**NOTE: A COPY OF A FORM OF AN OFFICIAL IDENTITY DOCUMENT MUST BE SENT TO THE DEPARTMENT; example**: driver's license, tribal ID card etc.

**INSTRUCTIONS TO COMPLETE**
**SFN 1168 Ownership/Controlling Interest and Conviction Information (4-2014)**
The following instructions apply to Individual QSPs.

I. Identifying Information. (Fill in the following)
- Name of Provider – Your first and last name
- Doing business as- **Write in 'N/A'** (for 'not applicable')
- Physical address - Write your street address. **A post office box cannot be used for this section.**
- City - City related to your address; State - State related to your address; Zip code - Zip code related to your address
- Mailing Address – write in if you have a different address that is used for mailing
- Telephone number – The number to be used to contact you
- Fax number – The number for your faxes if you have a private line
- Provider number- the QSP provider number assigned to you (if a new enrollee **write 'NA**.')
- NPI Number- **write in 'N/A'**
- E-Mail Address – Your primary email address

II. Certification
- **Write N/A**

III. Direct/Indirect Ownership Information
- **Write in your name and information in the first section. As a self-employed individual you are 100% owner of your business.**

IV. Managing Employee/Control Interest
- **Fill in your information as the managing employee**

V. Ownership/Controlling interest Information
- **Read the first question and answer Yes or No. If the answer is yes fill in the required information. If No go to the next section.**

VI. Changes in Provider Status
- **Read each question. The answers will likely be No as you are the owner.**

VII. Conviction Information
- **Mark Yes or No to the question** "Are there any directors, officers, agents, managing employees, or subcontractors of the institution, agency, or organization who have been convicted of or pled guilty to a criminal offense related to programs under Medicare, Medicaid, or Title XX Services Program? " **If you mark yes**, complete the rest of the section. If you mark no, go to the next section.

VIII. Multiple Owner Information
- **Mark Yes or No to the question. It will be yes** if you have ownership rights or are a member of a board for a facility that provides services billed to Medicaid or Medicare. The provider number would be the number associated with that facility. If you mark yes complete the rest of the section. If you mark no, go to section VIII.

IX. Chain Affiliations
- **Write in "N/A" for section**

X. Signature
a. Type or print your name in the Name of Authorized Representative box.
b. You must write in your date of birth and Social Security Number
c. Title - write in "N/A"
d. **Signature - sign the document with your signature.**
e. **Date - put in the date this form was completed.**

**INSTRUCTIONS TO COMPLETE**
**SFN 433 Child Abuse and Neglect Inquiry Form**

**Part I: Agency/Organization Information**

- If not prefilled, write HCBS/Medical Services

**Part II: Authorization for Release of Information**

- Check both boxes and **initial** both lines
- Check "other for "This information is being requested for" After other write QSP.
- When writing your name, you must include your FULL LEGAL NAME including your FULL MIDDLE NAME.
- If no middle name-Check the box None
- If you have no former last name within the last 10 years, please make sure to check the box indicating none. This is for males and females.
- Complete all other boxes with your addresses.
- Sign and Date

**Failure to follow the above instructions may result in a delay in your application.**

**Part III: Do Not Write Below – State Office Use Only**

- Leave Blank

## Return this completed form with the other Qualified Service Provider enrollment forms.

If this form is returned to you by the HCBS Staff due to being incomplete, please return with all requested information and instructions.

**INSTRUCTIONS TO COMPLETE**
**SFN 615 Medicaid Program Provider Agreement**

Provider – your name.

NPI – write NA (not applicable)

Medicaid Provider Number – write NA

Address – write your **street** address – a PO BOX will not be accepted.

City – the city for your address.

State – the state for your address.

ZIP Code – the zip code for your address.

READ THE AGREEMENT.
CONTACT HCBS IF ANY QUESTIONS.
THEN SIGN YOUR NAME IN THE 'PROVIDER/TITLE' BOX AND WRITE IN THE DATE SIGNED.

## Check your Application paperwork for completeness.

# NOTE:

- **Fill out a W9 if new application or reapplying**
- **Attach a voided check on new, renewal, and reenroll**

## Forms can be found on the website nd.gov

- SFN **1604** Request to be a Qualified Service Provider for Family Home Care
  http://www.nd.gov/eforms/Doc/sfn01604.pdf

- SFN **433** CHILD ABUSE AND NEGLECT BACKGROUND INQUIRY
  http://www.nd.gov/eforms/Doc/sfn00433.pdf

- SFN **615** MEDICAID PROGRAM PROVIDER AGREEMENT
  http://www.nd.gov/eforms/Doc/sfn00615.pdf

- W-9 REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION
  http://www.irs.gov/pub/irs-pdf/fw9.pdf

- SFN **1168** OWNERSHIP/CONTROLLING INTEREST AND CONVICTION INFORMATION
  http://www.nd.gov/eforms/Doc/sfn01168.pdf

## Always Keep A Copy Of The Most Current Handbook.

Qualified Service Family Home Care Handbook link:
http://www.nd.gov/dhs/info/pubs/docs/medicaid/qsp-handbook-family-home-care.pdf
. This link will always have the most current handbook.